Orthopedic Physical Therapy

[Clinic Name]
[Address Line 1]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
ID/DOB: _____
Referring MD: _____

BILLING INFORMATION

Payer: _____
Claim #: _____
ICD-10: _____

Date	Service / CPT Code	Description	Hours/Units	Rate	Total

Subtotal: $_____
Adjustments: $_____

Amount Due: $_____

Notes: ____

Tax ID / NPI: _______________________ | Make all checks payable to [Clinic Name]